DOH/61BOA 01/08

Return application to:
DWS/CIU
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500

Utah's Job Connection

Application

CHIP • PCN • UPP

Date Received

Case #: _____

1 What Do I Need to Do?

- ☐ Fill out this application and return.
- ☐ Have your employer or HR representative fill out the "Employer's Health Insurance Form" (attached) and return.
- ☐ Wait for your local eligibility office to contact you within two weeks. **You will be considered for all programs that are now open for enrollment.**
- ☐ Be prepared to show proof of income.

2 General Information

Name: _____
first middle initial maiden last

Street Address: _____
street apt. # city state zip

Mailing Address: _____
street apt. # city state zip

Home Phone: (_____)_____ Daytime/Cell Phone: (_____)_____

E-mail: (optional) _____

3 Household Information

List all the people who live in your home. Start with yourself. (Extra space available on back.)

Name (first, m.i., last)	Relation to You	Social Security Number*	Date of Birth mm/dd/yy	Sex M/F	Race **	Eth. **	Marital Status **	U.S. Citizen or Legal Alien ID*
(Start with yourself.)	self							☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____

*Social Security Number and citizenship information are only needed for the people applying for benefits; SSN is optional for children.

Race Codes: **AI-American Indian/Alaskan Native, **AS**-Asian, **BL**-Black, **PI**-Pacific Islander, **WH**-White (You may choose more than one.)
Ethnicity codes: **H**-Hispanic/Latino, **N**-Non-Hispanic **Marital status:** Single, Married, Divorced, Widowed, etc.

4 Income

List any income received by all people who live in your home. Examples include income from alimony, child support, unemployment, Social Security, VA benefits, pensions, etc. (Extra space available on back.)

Person Receiving Money (name)	Employer Name or Other Income Type	Pay Rate Before Taxes ($900/mo., $6/hr., etc.)	Hours Worked Weekly	How Often Paid (wkly, every 2 wks, 2x mo., monthly, etc.)
		/		
		/		
		/		

5 Other Information

☐Yes ☐No A. Is everyone in your household a Utah resident?

☐Yes ☐No B. Do you or your spouse have access to an employer's health insurance plan?

☐Yes ☐No C. Is anyone in your household currently enrolled in a health insurance plan?
If yes: Name(s)_____
When did coverage begin?(mm/dd/yy)_____

☐Yes ☐No D. Has anyone in your household dropped/changed health insurance in the last six months?
If yes: Name(s)_____
When was it dropped/changed?(mm/dd/yy) _____
Why?_____
Insurance company name: _____ Phone: _____

☐Yes ☐No E. Have you or your spouse ever served in the U.S. military?
If yes: Name(s)_____ Dates of service: _____

☐Yes ☐No F. Is any adult (19 or older) in your household a full-time student?
If yes: Name(s)_____ Name of School(s) _____

☐Yes ☐No G. Is anyone in your household pregnant or planning to adopt a child in the next 60 days?
If yes: Name(s)_____ Due date/when? _____

☐Yes ☐No H. Is anyone in your household disabled?
If yes: Name(s) _____

☐Yes ☐No I. Does your household have more than $3,000 in assets? (Do not include the home you live in.)

☐Yes ☐No J. Does your household have more than $500 in taxable interest income per year?

☐Yes ☐No K. I have the Employer's Health Insurance Form (last page) and will take it to my employer.

L. What is your family's preferred language? _____

Voter Registration Information

☐Yes ☐No If you are not registered to vote where you live now, would you like to apply to register to vote here today? If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor, State of Utah, PO Box 142220, SLC, UT 84114.

6 I Understand that:

- ☐ I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. Department of Workforce Services (DWS) will verify alien registration numbers with the U.S. Citizenship and Immigration Services (USCIS). DWS will not report undocumented household members to USCIS.
- ☐ DWS does not discriminate on the basis of race, ethnicity, religion, gender or disability.
- ☐ I give permission for any information listed on this form to be verified when I apply and after I receive benefits. DWS may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.
- ☐ I authorize any person or organization to release medical records or information about my health or the health of my dependents to DWS or designee. The Utah Department of Health (UDOH) and DWS may give health care providers information about my eligibility for medical benefits.
- ☐ I must report any changes in my address, phone number, household size and access to coverage by another health insurance program.
- ☐ The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I agree that these manuals may be amended without my consent or consideration.
- ☐ The benefits I am eligible to receive may be changed without my knowledge or consent. I agree to be responsible for any co-pays to providers at the time of medical service unless I am exempt from those co-pays.
- ☐ If I receive a medical card, I will allow only the people named on the medical card to use the card.
- ☐ I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family unless I have good cause.
- ☐ As necessary, the information on this application may be used to determine Medicaid eligibility.
- ☐ My benefits may be reduced, denied or stopped because of reported information. I understand that giving any false information or failing to report changes may result in prosecution for fraud.
- ☐ If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received. If the UDOH pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the UDOH any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the DWS or the Office of Recovery Services and will hold harmless any party making payment to them.
- ☐ I may ask for a fair hearing if I disagree with the decision made on this application.
- ☐ The Utah Statewide Immunization Information System (USIIS) is a registry that keeps complete up to date records of your child's immunization history. For more information, or to withdraw your child from USIIS, call the Immunization Hotline at 1-800-275-0659.
- ☐ In the event of my and my spouse's death, the State has the right to recover from my estate all money spent to pay my medical bills if I receive PCN and/or Medicaid at any time while I am 55 years of age or older.
- ☐ I agree to follow the UDOH rules. My spouse and/or children, as applicable, also agree to these rules.

I, (print name) _____, have read or had someone read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.

_____ _____

Signature of Applicant or Representative Date

☐Yes ☐No I would like my representative to also receive information regarding my case.

Name, address, phone: _____

_____

Additional Household Information

Name (first, m.i., last)	Relation to You	Social Security Number*	Date of Birth mm/dd/yy	Sex M/F	Race **	Eth. **	Marital Status **	U.S. Citizen or Legal Alien ID*
(Start with yourself.)	self							☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____
								☐U.S. ☐LA #_____

Additional Income

Person Receiving Money (name)	Employer Name or Other Income Type	Pay Rate Before Taxes ($900/mo., $6/hr., etc.)	Hours Worked Weekly	How Often Paid (wkly, every 2 wks, 2x mo., monthly, etc.)
		/		
		/		
		/		
		/		
		/		
		/		

Employer's Health Insurance Information

Date Received

Case #: _____

☐ This form MUST be completed by your employer or your company's Human Resources representative. Any blanks left on this form may delay the process.

☐ A form must be completed for each employed household member.

1 General Information

Employee Name : _____ SSN: _____

Company Name: _____ EIN: _____

☐Yes ☐No A. Does your company offer health insurance? If no, skip to section 4. Sign and return the form.

☐Yes ☐No B. Is the employee eligible to enroll in any insurance plan offered?
If no, please explain: _____
If yes, when is/was the employee eligible to enroll? (mm/dd/yy) _____

☐Yes ☐No C. Is the employee or any family member enrolled in any insurance plan offered?
If yes, name(s) of persons enrolled: _____
_____
_____

☐Yes ☐No D. Has this employee or any family member dropped/changed coverage in the last six months?
If yes, name(s): _____
If yes, when did coverage end/change? (mm/dd/yy) _____

2 Least Expensive Plan

Questions below refer to the ***least expensive*** plan offered at your company.

☐Yes ☐No A. Does the employee have to enroll in order to add their dependent(s)?

B. When will/did coverage begin? (mm/dd/yy) _____

C. When does the company's next open enrollment begin? (mm/dd/yy) _____

D. Complete the chart below. **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

E. Please list the yearly health plan deductible (not the "out of pocket" cost or hospital deductible).
Individual amount $_____ Family amount $_____

☐Yes ☐No F. Does the plan pay for any services (doctor, pharmacy, etc.) before the employee has met the deductible listed above?

(continued)

3 Employee's Health Plan Choice

Questions below refer to the plan the employee has selected. Questions B-G refer to "in-network" benefits.

A. Insurance company and plan name: _____

☐Yes ☐No B. Is the deductible $1000 or less per individual?

☐Yes ☐No C. Does the plan pay at least 70% of an inpatient stay (after the deductible)?

☐Yes ☐No D. Is the lifetime maximum benefit $1,000,000 or more?

E. What benefits are covered under this plan? (Check all that apply.)

☐ Physician visits ☐ Hospital inpatient services ☐ Pharmacy/Rx
☐ Well child exams ☐ Child immunizations

F. Complete this chart only if it is different from the chart on the front page (section 2). **Do not** include the cost of dental, vision or other coverage if it is separate.

Monthly Premium		
	Employee's Portion	Company's Portion
Employee	$	$
Employee + spouse	$	
Employee + child	$	
Family	$	

☐Yes ☐No G. Are the employee's children currently enrolled or do they plan to enroll in your company's dental plan? If yes, name(s):_____

4 Signature

I certify that I am a representative of the Human Resource Department, or that I am the health insurance contact person. The information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Name (please print): _____

Title: _____ Phone: _____

Please return completed form to:

DWS/CIU
PO Box 143245
SLC, UT 84114-3245
Fax: 801-526-9500